DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Poc #1 acceptable

PRINTED: 02/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPALACHIAN CHRISTIAN VILLAGE	2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A revisit was completed at Appalachian Christian Village on February 15, 2011, following acceptance of the Allegation of Compliance to remove the Immediate Jeopardy at F-223, F226, and F490, Scope and Severity level "J." The revisit revealed the corrective actions implemented February 13, 2012, removed the Immediate Jeopardy at F-223, F226, and F490, but non-compliance continues at a "D" level for F-223, F226, and F490. The facility is required to submit a plan of correction for all outstanding tags.	{F 000}		
{F 223} SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on survey results dated January 31, 2012, the facility failed to ensure two Residents (#1 and #2) with Dementia were free from physical and mental abuse of five Residents reviewed. The facility failed to stop and report the abuse immediately, allowing three alleged perpetrators, to continue to abuse the victims. The facility provided an acceptable Credible Allegation of Compliance on February 13, 2012. A revisit conducted on February 15, 2012,	{F 223}		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

See Page 2 for Signature

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Allen Dobbs NHA | TITLE: Administrator | (X6) DATE: 2/29/2012

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{F 223}	Continued From page 1 revealed the corrective actions, implemented on February 13, 2012, removed the Immediate Jeopardy. Non-compliance for F-223 continues at a "D" level scope and severity. Validation of the Credible Allegation of Compliance was accomplished through facility policy review, review of inservice records, interview with staff, administrative personnel, residents and families, and observation. The facility provided evidence of new policies and procedures which was implemented on January 23, 2012, related to the enforcement of stopping and reporting abuse immediately and the enforcement of the cell phone policy, which prohibited the use of personal cell phones and cameras in the facility. Inservice and training records including sign-in sheets for all staff related to the new policies were provided. The sign-in sheets for the training records were compared to a listing of all employees and confirmed 100% (percent) of all employees had been trained on the new policies. Interview with staff, including Certified Nursing Assistants (CNA's), Restorative Nursing Assistants (RNA's), Licensed Practical Nurses (LPN's), Registered Nurses (RN's), Environmental Services (Housekeeping/Laundry), Physical Therapist (PT), and Director of Nursing (DON) confirmed staff had been inserviced on the abuse and reporting policies, cell phone policies, and the likelihood of termination for not stopping and reporting abuse, or if caught with a personal cell phone in the facility. Continued interview confirmed at the beginning of each staff rotation, Charge Nurses question staff to ensure	{F 223}	• 1/14/12: After being notified of the allegation, the RN Supervisor did not allow CNA #2, #3, or #4 to enter Resident #1's room and/or perform any care unattended by the RN for the remainder of the shift. At this time, the RN did not know that Resident #2 had been involved in the event that occurred to Resident #1. 1/20/12 was the date the involvement of Resident #2 was discovered. However, all residents assigned to CNAs #2, #3 and # 4 were closely monitored for the remainder of the shift. Resident #2 was in that assignment which was supervised by the RN Supervisor and the Licensed Practical Nurse (LPN) Staff Nurse. Other residents were observed and assessed to ensure appropriate care had been rendered and also observed for signs similar to those reported in the event involving Resident #1 (wet gowns, wet pillow cases, water on the wall or bed). No further signs of unusual or unexpected abuse as observed with Resident #1 were identified by the RN Supervisor or the LPN Charge Nurse during the remainder of the shift. • 1/20/12: MDS assessment was reviewed by Minimum Data Set (MDS) RN. The plan of care was reviewed and revised by the Interdisciplinary Care Plan Team members to reflect the improvement of behaviors. The Interdisciplinary Care Plan Team consisted of: MDS Nurse, Certified Dietary Manager, and the Activities Coordinator. • 1/19/12: Resident #1's husband was notified by the Chief Executive Officer (CEO), Administrator and Director of Nursing (DON) of the allegation. The CEO, Administrator and DON met with the husband on 1/19/12.	

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{F 223}	Continued From page 2 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 1/20/12: Two daughters were notified by CEO, Administrator, and DON and they met with one of the daughters that same day. • 1/20/12: Attending physician was notified by the Assistant Director of Nursing (ADON) of the reported allegation. • 1/20/12: A sitter was provided by the facility on the night shift (7p-7a). • 1/20/12: Resident #1 was sent to the Emergency Room where a physical exam was performed to ensure no physical/bodily harm had occurred. Findings were negative for any type of physical abuse/harm. • 1/24/12: Resident #1 was evaluated by the Geropsychiatric Nurse Practitioner. Findings: Not significant for mood/behavior changes, documented as "calm and cooperative". • 2/9/12: Administrator requested the Geropsychiatric Nurse Practitioner visit Resident #1 every 2 weeks for at least 2 months. Order obtained by LPN Charge Nurse. RESIDENT #2 • 1/20/12: The Administrator notified the son of the reported allegation. The son did not want to meet, but wanted to discuss the matter on the phone. Administrator offered to have the resident sent to the hospital for a physical exam, but the son declined the offer. • 1/20/12: Skin audit was completed by the Wound Care Nurse on 1/20/12. Findings: Skin intact with no other significant findings.	

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{F 223}	Continued From page 8 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 1/26/12: The roster of current individuals employed at Appalachian Christian Village was used to ensure each employee was contacted and instructed on the revised policies. Acknowledgement forms have been signed and are maintained in each employee's personnel file by Human Resources personnel of Appalachian Christian Village. A list of persons in-serviced is attached for reference **(See Attachment "C")** • Any employee off duty, on leave of absence or vacation, was contacted and required to come to the management office-HR department, or received by mail the specific information for policy changes, or phone conversations took place with these employees for detailed explanation and assurance of their understanding of policy changes, completed by January 26, 2012. No agency employees were being used at the time. No employees were allowed to return to work until these in-services and policy revisions were conducted and acknowledgement received from them. • 1/23/12 – 1/26/12: Contract employees were issued hard copies of the employee notice of the Crimes Reporting policy, with acknowledgements signed by each contract employee. These signed acknowledgements are maintained by the Human Resources Director in her files at the Management office. **(See Attachment "D" for Crimes reporting requirement notice to employees)** • 2/7/12: Staff is asked by Charge Nurses at the beginning of each staff rotation if they understand the cell phone policy and if they have cell phones with them. If found non-compliant, cell phones are taken immediately, per policy. **(See Attachment "J" for New Rotation Rounds policy)**	

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	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

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{F 223}	Continued From page 4 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 2/10/12: Human Resources notified all nursing supervisory personnel (DON, ADON, MDS Nurse, RN Supervisor, and LPN Charge Nurse) to complete the "Management/Leadership" in-service. The titles of the courses are: "Critical Thinking – Implications for Long Term Care Leadership"; "Coaching: Implications for Long Term Care Leadership"; and "Ethical Decision Making in Senior Care." Pre and post test scores will be reviewed by the DON and ADON to determine staff competency and if further education is needed. **(See Attachment "J")** • To comply with Federal regulations, the Crimes Reporting Policy was posted 1/1/12 and issued to each of the employees through the Silver Chair Education program by the Human Resources Training Coordinator. The Silver Chair Education program is a program that focuses exclusively on the training and education of employees in Senior Care organizations. **(See Attachment "E")** **2) How other residents were identified as having the potential to be affected by the same deficient practice and corrective actions taken:** • 1/20/12 through 2/9/12: Fifty-five (55) family members were contacted and/or interviewed by the Social Services Coordinator regarding any changes in personality, mood or behavior they may have noticed in that resident within the last 3 months. Findings: Issues/concerns reported were forwarded to the DON for follow-up and corrective action.	

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{F 223}	Continued From page 10 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 1/24/12 through 2/7/12: Thirty-three (33) alert and oriented residents with a BIM score of 10 or above on the most recent MDS assessment were interviewed by the Quality Assurance (QA) Nurse and Social Worker/Admissions Coordinator regarding any inappropriate behavior or suspected abuse, neglect or harm. Specific questions were used to conduct the interview. The results of the interview were documented on the sheet with the questions for each individual resident. Findings: No complaints, issues were voiced. No suspected abuse/harm was voiced and/or identified. • 2/6/12: Residents with dementia and/or residents who are not interviewable were evaluated for any mood or behavior changes that might indicate any mistreatment or incident of abuse by 8 LPN charge nurses. Findings: No changes or issues identified. The results of the evaluations were documented in nurse's notes. No suspected abuse/harm was voiced and/or identified. • 2/8/12: Facility engaged the services of an Independent Nurse Consultant to assist with the AOC process and system implementation to address issues identified in the statement of deficiencies. The Nurse Consultant will continue to evaluate compliance during routine visits. • 2/8/12: The DON and ADON developed an additional resident monitoring process. **(See Attachment "F")**	

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{F 223}	Continued From page 11 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 2/8/12 – 2/11/12: All residents were given a copy of "Resident Rights" by the Social Services Coordinator. Twenty-three (23) were mailed to the family or power of attorney (POA) (for residents who were considered to have cognitive impairment) and seventy-three (73) were given to residents and signed. • 2/8/12 – The facility Administrator began contacting individuals/companies to engage them to provide services as outlined in the Federal Directed Plan of Correction: 1) Independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and any agency staff providing services within the facility, 2) To evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care, 3) Conduct training for the governing body and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect, 4) Provide information to residents during a resident council meeting on abuse, 5) Conduct on a weekday and weekend a meeting with family council or with family members if a council has not been established. The following were contacted: 1) Psychologist, PhD referred by Legal Nurse Consultant who specializes in this type of training, 2) Geriatric Psychiatric Physicians group 3) RN – Certified in Psychiatric Nursing, 4) Quality Improvement Organizations (Q Source) "*Sharing Knowledge, Improving Health Care, Centers for Medicare and Medicaid Services*, 5) A Master in Social Work (MSW), 6) Regional Administrator of a Long Term Care	

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{F 223}	Continued From page 12 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	Corporation, 7) IPC (Inpatient Care Services) and 8) Tennessee Technology Center – RN Educators. On 2/22/12 the facility CEO and Administrator agreed verbally to engage the services of Lipscomb University with [illegible] the [illegible], Dean of the New College of Professional Studies and the School of TransformAging. On 2/27/12 a contract was signed for those services. Services are planned to begin 2/28/12 and end 3/9/12. (See Attachment "O" for the contract). • 2/11/12: Letters were mailed by the Social Services Coordinator to family members to determine if they are interested in establishing a Family Council. **(See Attachment "G")** **3) Measures or systematic changes put into place to ensure the deficient practice does not reoccur.** • 1/23/12: The "Abuse Prevention Policy" and the "Cellular Phone Usage Policy" were revised by the facility's attorney, with approval of the CEO, the Administrator and the Human Resources (HR) Director. ABUSE PREVENTION POLICY REVISIONS The content of the revised "Abuse Prevention Policy" training included (revisions in bold italics): *"employees shall immediately report to their supervisor any alleged incidents or suspicions of abuse, neglect, involuntary seclusion and/or misappropriation of resident's property. Incidents include: staff to resident, resident to resident, resident to staff, staff to staff and*	

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{F 223}	Continued From page 17 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 2/14/12: All nursing supervisory personnel (DON, ADON, MDS Nurse, RN Supervisor, and LPN Charge Nurse) had completed the "Management/Leadership" in-service. The titles of the courses are: "Critical Thinking – Implications for Long Term Care Leadership"; "Coaching: Implications for Long Term Care Leadership"; and "Ethical Decision Making in Senior Care." **(See Attachment "J")** • 2/15/12: Pre and post test scores were reviewed by the DON and ADON to determine staff competency and if further education is needed. Results: 15 = 100 and 11= 90. • 1/27/12: The Administrator and Director of Nursing reviewed the function of RN supervisors, LPN charge nurses, and the Quality Assurance LPN. • 3/4 & 5/12: The Social Worker implemented a Family Council based on 10 favorable responses from family members who expressed an interest in the council. **(See Attachment "P" for Family Council information).** • 2/8/12: The DON and ADON developed an additional resident monitoring process to monitor resident care and if care was given in a compassionate, caring manner. The charge nurse conducts clinical rounds for his/her assignment at least 2 times each shift Results are recorded on the "Clinical Round Worksheet" and forwarded to the DON and or ADON. **(See Attachment "F").**This monitoring process is ongoing.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 223}	Continued From page 18 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 1/31/12: A grievance program was developed and implemented by the Director of Nursig. The DON will maintain a logoff complaints and will follow up on each complaint regarding patient care issues promptly. This program is in addition to the current policy/procedure in place that is overseen by the Social Services Coordinator. Complaint/grievance reporting forms are located by the bulletin board that houses the public postings and information. These forms are assesssable to all employees, residents, family and visitors. **(See Attachment "H")** • 2/8/12: Facility engaged the services of an Independent Nurse Consultant to assist with the POC process and system implementation to address issues identified in the statement of deficiencies. The Nurse Consultant will continue to evaluate compliance during routine visits. • 2/8/12: Additional rounds were implemented to be conducted by the Management team. Members of the management team (Administrator, DON, ADON, QA nurse, MDS nurses, Social Worker/Admission Coordinator and Activities Coordinator) will round in the facility at least once daily on the night shift between 12mn and 7am, every day for at least 30 days to monitor resident care and interaction.	

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{F 223}	Continued From page 19 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 2/11/12: Process was developed to enhance the communication between the DON/ADON and the Administrator of daily activities that occur in the Health Care Center during "Off" hours and weekends. "Off" hours are defined as hours outside the normal work scheduled times (8:00 a.m. – 4:30 p.m.) **(See Attachment "K")** • 2/7/12: Staff is asked by Charge Nurses at the beginning of each staff rotation if they understand the cell phone policy and if they have cell phones with them. If found non- compliant, cell phones are taken immediately, per policy. **(See Attachment "I" for New Rotation Rounds policy)** **4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i. e. quality assurance measures implemented.** • 2/14/12: The Quality Assurance Nurse will monitor resident care, call light response times, direct care staff to resident interaction, resident conditions, family/visitor concerns during daily rounds Monday – Friday. These rounds will also be conducted at least 1 shift on a weekend each month. This monitoring process is ongoing **(See Attachment L).**	

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{F 223}	Continued From page 20 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• 2/14/12 – Social Services Coordinator and/or the Social Worker/Admissions Coordinator will ~~randomly~~ interview 5 cognitive/interviewable residents (selecting different residents each week) to determine if care is provided in a caring compassionate manner and if they have noticed any behavior from staff that may be consistent with abuse or neglect. These interviews will be completed weekly times 2 weeks, then monthly times 3 months and quarterly thereafter. **(See Attachment M).** • 2/14/12 – Human Resources will conduct interviews with at least 10 employees of all disciplines (selecting different employees each week) to determine if they are knowledgeable of the Abuse Prevention policy and Cell Phone Policy, weekly times 2 weeks, then monthly times 3 months, then quarterly thereafter. **(See Attachment N).** • The results of the Quality Assurance Monitoring mentioned above will be reviewed and discussed in the monthly facility Quality Assurance Meeting. The information will be presented as follows: 1) Attachment F: Clinical Rounds by DON 2) Attachment L: Clinical Rounds by QA Nurse 3) Attachment M: Resident Interviews by Social Services Coordinator 4) Attachment N: Human Resources Director 5) Meeting minutes from Family Council Meetings	

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{F 223}	Continued From page 21 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}	• The Administrator will issue a written report weekly of any activity related to suspected Abuse and or Neglect to the CEO weekly for the next 4 weeks, then monthly for 3 months and quarterly thereafter. The CEO will review the report to determine if appropriate interventions were taken to protect the residents residing in Health Care and if facility policy was followed. The CEO or Administrator will present this information to the QA committee for review and discussion in the first monthly meeting following the fourth weekly report, and quarterly thereafter. The CEO will also present this information to the Governing Board at the quarterly Board meetings.	

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FORM APPROVED
OMB NO. 0938-0391

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{F 223}	Continued From page 22 understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medication rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 223}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	{F 226}	**F226** **1) The corrective actions that have been accomplished for the two residents found to have been affected by the deficient practice:** **RESIDENT #1** • 1/14/12: Clothing and bed linens were changed by Certified Nursing Assistants (CNA) #3 and #8 after having been found wet by Registered Nurse (RN) #1 under the supervision of RN #1.	3/9/12

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{F 226}	Continued From page 23 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on survey results dated January 31, 2012, the facility failed to ensure two Residents (#1 and #2) with Dementia were free from physical and mental abuse of five Residents reviewed. The facility failed to follow facility policy to report abuse immediately and remove the alleged perpetrators and protect the residents, allowing the three alleged perpetrators to continue to abuse the victims. The facility provided an acceptable Credible Allegation of Compliance on February 13, 2012. A revisit conducted on February 15, 2012, revealed the corrective actions, implemented on February 13, 2012, removed the Immediate Jeopardy. Non-compliance for F-223 continues at a "D" level scope and severity. Validation of the Credible Allegation of Compliance was accomplished through facility policy review, review of inservice records, interview with staff, administrative personnel, residents and families, and observation. The facility provided evidence of new policies and procedures which were implemented on January 23, 2012, related to the enforcement of following the policy to stop and report abuse immediately and the enforcement of the cell phone policy, which prohibited the use of personal cell phones and cameras in the facility.	{F 226}	• 1/14/12: After being notified of the allegation, the RN Supervisor did not allow CNA #2, #3, or #4 to enter Resident #1's room and/or perform any care unattended by the RN for the remainder of the shift. At this time, the RN did not know that Resident #2 had been involved in the event that occurred to Resident #1. 1/20/12 was the date the involvement of Resident #2 was discovered. However, all residents assigned to CNAs #2 #3 and # 4 were closely monitored for the remainder of the shift. Resident #2 was in that assignment which was supervised by the RN Supervisor and the Licensed Practical Nurse (LPN) Staff Nurse. Other residents were observed and assessed to ensure appropriate care had been rendered and also observed for signs similar to those reported in the event involving Resident #1 (wet gowns, wet pillow cases, water on the wall or bed). No further signs of unusual or unexpected abuse as observed with Resident #1 were identified by the RN Supervisor or the LPN Charge Nurse during the remainder of the shift. • 1/20/12: MDS assessment was reviewed by Minimum Data Set (MDS) RN. The plan of care was reviewed and revised by the Interdisciplinary Care Plan Team members to reflect the improvement of behaviors. The Interdisciplinary Care Plan Team consisted of: MDS Nurse, Certified Dietary Manager, and the Activities Coordinator. • 1/19/12: Resident #1's husband was notified by the Chief Executive Officer (CEO), Administrator and Director of Nursing (DON) of the allegation. The CEO, Administrator and DON met with the husband on 1/19/12.	

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{F 226}	Continued From page 24 Inservice and training records including sign-in sheets for all staff related to the new policies were provided. The sign-in sheets for the training records were compared to a listing of all employees and confirmed 100% (percent) of all employees had been trained on the new policies. Interview with staff, including Certified Nursing Assistants (CNA's), Restorative Nursing Assistants (RNA's), Licensed Practical Nurses (LPN's), Registered Nurses (RN's), Environmental Services (Housekeeping/Laundry), Physical Therapist (PT), and Director of Nursing (DON) confirmed staff had been inserviced on the abuse and reporting policies, cell phone policies, and the likelihood of termination for not stopping and reporting abuse, or if caught with a personal cell phone in the facility. Continued interview confirmed at the beginning of each staff rotation, Charge Nurses question staff to ensure understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Random interviews with alert and oriented residents and with family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medicine rooms. Observation revealed no cell phones were observed being used in the facility. Based on review of facility abuse and cell phone	{F 226}	• 1/20/12: Two daughters were notified by CEO, Administrator, and DON and they met with one of the daughters that same day. • 1/20/12: Attending physician was notified by the Assistant Director of Nursing (ADON) of the reported allegation. • 1/20/12: A sitter was provided by the facility on the night shift (7p-7a). • 1/20/12: Resident #1 was sent to the Emergency Room where a physical exam was performed to ensure no physical/bodily harm had occurred. Findings were negative for any type of physical abuse/harm. • 1/24/12: Resident #1 was evaluated by the Geropsychiatric Nurse Practitioner. Findings: Not significant for mood/behavior changes, documented as "calm and cooperative". • 2/9/12: Administrator requested the Geropsychiatric Nurse Practitioner visit Resident #1 every 2 weeks for at least 2 months. Order obtained by LPN Charge Nurse. RESIDENT #2 • 1/20/12: The Administrator notified the son of the reported allegation. The son did not want to meet, but wanted to discuss the matter on the phone. Administrator offered to have the resident sent to the hospital for a physical exam, but the son declined the offer. • 1/20/12: Skin audit was completed by the Wound Care Nurse on 1/20/12. Findings: Skin intact with no other significant findings.	

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{F 226}	Continued From page 25 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 1/24/12: The resident was examined by the Geropsychiatric Nurse Practitioner. Results: No changes, continue current medication. • 2/9/12: The Administrator requested the Geropsychiatric Nurse Practitioner visit Resident #2 every 2 weeks for at least 2 months. Order obtained by LPN Charge Nurse. RESIDENT #1 and #2 • 1/17/12: CNAs #2, 3, and 4 were placed on Administrative leave without pay. • 1/17/12: The Administrator and DON viewed CNA #2's cell phone picture gallery. Findings: There were no pictures present of Resident #1, #2, or of any other residents. • 1/19/12: CNAs # 2, 3 and 4 were reported to the local law enforcement by the Administrator. • 1/20/12: After further investigation CNA's #2, 3, and 4 were terminated from employment. • 1/23/12: CNAs #5 and #8 were terminated from employment for failure to report abuse and for providing false information during the investigation.	

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{F 226}	Continued From page 86 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 1/23/12: The review of policies "Abuse Prevention", "Cellular Phone Usage" and "Crimes Reporting" was conducted by the facility's attorney, the CEO, the Human Resources Director, the Administrator and the Director of Nursing. The revisions of the "Abuse Prevention Policy" and the "Cellular Phone Usage Policy" were carried out by the facility's attorney, with approval of the CEO, the Administrator and the Human Resources (HR) Director. • 1/24/12: Human Resources Director disciplined CNA #7 with a final written warning for failure to report suspected abuse and failure to report violations of the cellular phone usage policy. • 1/24/12: CNA #1, who originally reported the incident, was disciplined by Human Resources for failure to timely report any suspicion of abuse and report usage of cell phone at work as in Appalachian Christian Village polices 1) Abuse Prevention and reporting and 2) Cell Phone Usage. A final written warning was issued and placed in the employee's file. • 1/25/12: Human Resources Director disciplined RN #1 with a final written warning and one day suspension (1/26/12). • 1/25/12: CNA #1 sent an email to the Administrator with his resignation without notice. • 1/25/12: Human Resources Director disciplined CNA #6 with a final written warning for failure to report suspected abuse and failure to report violations of the cellular phone usage policy.	

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{F 226}	Continued From page 27 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 1/26/12: Human Resources Director disciplined LPN #1 with a one day suspension (1/26/12). ABUSE PREVENTION POLICY REVISIONS The content of the revised "Abuse Prevention Policy" training included (revisions in bold italics): *"employees shall immediately report to their supervisor any alleged incidents or suspicions of abuse, neglect, involuntary seclusion and/or misappropriation of resident's property. Incidents include: staff to resident, resident to resident, resident to staff, staff to staff and visitor to resident.* ***Any employee, who is made aware of abuse or suspected abuse, must immediately report to their supervisor.*** *Any employee who fails to report an act or suspicion of abuse will be subject to discipline which may include termination."* **(See Attachment "A")** The revision to the "Abuse Prevention Policy" is the added statement: ***"Any employee who fails to report an act or suspicion of abuse will be subject to discipline which may include termination."*** The Administrator of Appalachian Christian Village shall serve as the Abuse Coordinator.	

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	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPALACHIAN CHRISTIAN VILLAGE	2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 28 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	CELL PHONE USAGE POLICY REVISIONS The revised cell phone usage policy states, with revisions in *bold italics:* "Appalachian Christian Village prohibits the use of personal cellular phones ***and cameras*** in any ACV owned building during working hours. Employees will be required to keep personal cellular phones ***and cameras*** in their vehicles and ***shall not use them while they are clocked in on ACV property.*** Employees are asked to ensure that friends and family members are aware of the company's policy. If an employee is caught with their personal cellular phone in an ACV building during working hours the cellular phone will be taken from them by their supervisor and will not be returned to them until the end of their shift. ***In the event of an emergency, employees may use the facility phones to receive or make calls."*** "Due to the fact that management staff members are on call 24 hours a day, most of them have been assigned a cellular phone for business ***use and may use them for legitimate business reasons while at work.*** Management staff is encouraged to regularly remind employees of their responsibilities in complying with this policy".**(See Attachment "B")** INSERVICES FOR ABUSE POLICY/REPORTING PROCEDURE AND CELL PHONE USAGE • 1/23/12: The HR Director was trained and in-serviced by the facility's attorney. • 1/24/12: The HR Director trained Management Staff (Administrator, DON, and ADON).	

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{F 226}	Continued From page 29 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 1/23/12 – 2/27/12: These policies and procedures have been reviewed, revised and re-issued with individual re-instruction to each and every employee of the facility and contract employees working within the facility. Facility staff was in-serviced by HR, Administrator, DON and/or the ADON. Employees that were trained/in-serviced included Quality Assurance LPN, MDS RN coordinator, MDS LPN, RN supervisors, LPN charge nurses, LPN wound care nurses, CNAs, Restorative CNAs, house aides, central supply clerk, medical records clerk, unit secretary, activities director, activities assistant, Social Services coordinator, admissions coordinator, therapy staff, dining services employees, housekeeping staff, laundry services staff, maintenance staff, personal care services staff and supervisor, receptionist, Resident Services Director, activities and wellness staff for independent living areas, Pharmacy Consultants, Couriers, and Information Technology (IT) Contractors, Attending Physicians, Medical Equipment Sales Representative and Service Personnel, Medical Supplies Sales Representative, Psychological Services – Nurse Practioner and Social Worker, Chemical Sales Representatives, Hospice, Phlebotomist, Newspaper Carrier, Care Coordinator for Medicaid State Insurance Program, Medical Director, Dentist, Dental Hygienist, Registered Dietician. • 1/24/12: New Hire Orientation information was updated to include the policy revisions for "Abuse Prevention" and "Cell Phone Usage."	

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{F 226}	Continued From page 30 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 1/26/12: The roster of current individuals employed at Appalachian Christian Village was used to ensure each employee was contacted and instructed on the revised policies. Acknowledgement forms have been signed and are maintained in each employee's personnel file by Human Resources personnel of Appalachian Christian Village. A list of persons in-serviced is attached for reference **(See Attachment "C")** • Any employee off duty, on leave of absence or vacation, was contacted and required to come to the management office-HR department, or received by mail the specific information for policy changes, or phone conversations took place with these employees for detailed explanation and assurance of their understanding of policy changes, completed by January 26, 2012. No agency employees were being used at the time. No employees were allowed to return to work until these in-services and policy revisions were conducted and acknowledgement received from them. • 1/23/12 – 1/26/12: Contract employees were issued hard copies of the employee notice of the Crimes Reporting policy, with acknowledgements signed by each contract employee. These signed acknowledgements are maintained by the Human Resources Director in her files at the Management office. **(See Attachment "D" for Crimes reporting requirement notice to employees)**	

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{F 226}	Continued From page 31 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 2/7/12: Staff is asked by Charge Nurses at the beginning of each staff rotation if they understand the cell phone policy and if they have cell phones with them. If found non-compliant, cell phones are taken immediately, per policy. **(See Attachment "I" for New Rotation Rounds policy)** • 2/10/12: Human Resources notified all nursing supervisory personnel (DON, ADON, MDS Nurse, RN Supervisor, and LPN Charge Nurse) to complete the "Management/Leadership" in-service. The titles of the courses are: "Critical Thinking – Implications for Long Term Care Leadership"; "Coaching: Implications for Long Term Care Leadership"; and "Ethical Decision Making in Senior Care." Pre and post test scores will be reviewed by the DON and ADON to determine staff competency and if further education is needed. **(See Attachment "J")** • To comply with Federal regulations, the Crimes Reporting Policy was posted 1/1/12 and issued to each of the employees through the Silver Chair Education program by the Human Resources Training Coordinator. The Silver Chair Education program is a program that focuses exclusively on the training and education of employees in Senior Care organizations. **(See Attachment "E")**	

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{F 226}	Continued From page 32 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	**2) How other residents were identified as having the potential to be affected by the same deficient practice and corrective actions taken:** • 1/20/12 through 2/9/12: Fifty-five (55) family members were contacted and/or interviewed by the Social Services Coordinator regarding any changes in personality, mood or behavior they may have noticed in that resident within the last 3 months. Findings: Issues/concerns reported were forwarded to the DON for follow-up and corrective action. • 1/24/12 through 2/7/12: Thirty-three (33) alert and oriented residents with a BIM score of 10 or above on the most recent MDS assessment were interviewed by the Quality Assurance (QA) Nurse and Social Worker/Admissions Coordinator regarding any inappropriate behavior or suspected abuse, neglect or harm. Specific questions were used to conduct the interview. The results of the interview were documented on the sheet with the questions for each individual resident. Findings: No complaints, issues were voiced. No suspected abuse/harm was voiced and/or identified. • 2/6/12: Residents with dementia and/or residents who are not interviewable were evaluated for any mood or behavior changes that might indicate any mistreatment or incident of abuse by 8 LPN charge nurses. Findings: No changes or issues identified. The results of the evaluations were documented in nurse's notes. No suspected abuse/harm was voiced and/or identified.	

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{F 226}	Continued From page 33 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• 2/8/12: Facility engaged the services of an Independent Nurse Consultant to assist with the AOC process and system implementation to address issues identified in the statement of deficiencies. The Nurse Consultant will continue to evaluate compliance during routine visits. • 2/8/12: The DON and ADON developed an additional resident monitoring process. **(See Attachment "F")** • 2/8/12 – 2/11/12: All residents were given a copy of "Resident Rights" by the Social Services Coordinator. Twenty-three (23) were mailed to the family or power of attorney (POA) (for residents who were considered to have cognitive impairment) and seventy-three (73) were given to residents and signed. • 2/8/12 – The facility Administrator began contacting individuals/companies to engage them to provide services as outlined in the Federal Directed Plan of Correction: 1) Independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and any agency staff providing services within the facility, 2) To evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care, 3) Conduct training for the governing body and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect, 4) Provide information to residents during a resident council meeting on abuse, 5) Conduct on a	

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{F 226}	Continued From page 34 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	weekday and weekend a meeting with family council or with family members if a council has not been established. The following were contacted: 1) Psychologist, PhD referred by Legal Nurse Consultant who specializes in this type of training, 2) Geriatric Psychiatric Physicians group 3) RN – Certified in Psychiatric Nursing, 4) Quality Improvement Organizations (Q Source) *"Sharing Knowledge, Improving Health Care, Centers for Medicare and Medicaid Services,* 5) A Master in Social Work (MSW), 6) Regional Administrator of a Long Term Care Corporation, 7) IPC (Inpatient Care Services) and 8) Tennessee Technology Center – RN Educators. On 2/22/12 the facility CEO and Administrator agreed verbally to engage the services of Lipscomb University with the Dean of the New College of Professional Studies and the School of TransformAging. On 2/27/12 a contract was signed for those services. Services are planned to begin 2/28/12 and end 3/9/12. **(See Attachment "O" for the contract)** • 2/11/12: Letters were mailed by the Social Services Coordinator to family members to determine if they are interested in establishing a Family Council. **(See Attachment "G")** **3) Measures or systematic changes put into place to ensure the deficient practice does not reoccur.** • 1/23/12: The "Abuse Prevention Policy" and the "Cellular Phone Usage Policy" were revised by the facility's attorney, with approval of the CEO, the Administrator and the Human Resources (HR) Director.	

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{F 226}	Continued From page 35 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	ABUSE PREVENTION POLICY REVISIONS The content of the revised "Abuse Prevention Policy" training included (revisions in bold italics): *"employees shall immediately report to their supervisor any alleged incidents or suspicions of abuse, neglect, involuntary seclusion and/or misappropriation of resident's property. Incidents include: staff to resident, resident to resident, resident to staff, staff to staff and visitor to resident.* ***Any employee, who is made aware of abuse or suspected abuse, must immediately report to their supervisor.*** *Any employee who fails to report an act or suspicion of abuse will be subject to discipline which may include termination."* **(See Attachment "A").** The Administrator of Appalachian Christian Village shall serve as the Abuse Coordinator. CELL PHONE USAGE POLICY REVISIONS The revised cell phone usage policy states, with revisions in ***bold italics:*** "Appalachian Christian Village prohibits the use of personal cellular phones ***and cameras*** in any ACV owned building during working hours. Employees will be required to keep personal cellular phones ***and cameras*** in their vehicles and ***shall not use them while they are clocked in on ACV property.*** Employees are asked to ensure that friends and family members are aware of the company's policy. If an employee is caught with their personal cellular phone in an ACV	

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{F 226}	Continued From page 36 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	building during working hours the cellular phone will be taken from them by their supervisor and will not be returned to them until the end of their shift. ***In the event of an emergency, employees may use the facility phones to receive or make calls."*** "Due to the fact that management staff members are on call 24 hours a day, most of them have been assigned a cellular phone for business ***use and may use them for legitimate business reasons while at work.*** Management staff is encouraged to regularly remind employees of their responsibilities in complying with this policy".**(See Attachment "B")** • 1/23/12: The HR Director was trained and in-serviced by the facility's attorney. • 1/24/12: The HR Director trained Management Staff (Administrator, DON, and ADON). • 1/23/12 – 2/27/12: These policies and procedures have been reviewed, revised and re-issued with individual re-instruction to each and every employee of the facility and contract employees working within the facility. Facility staff was in-serviced by HR, Administrator, DON and/or the ADON. Employees that were trained/in-serviced included Quality Assurance LPN, MDS RN coordinator, MDS LPN, RN supervisors, LPN charge nurses, LPN wound care nurses, CNAs, Restorative CNAs, house aides, central supply clerk, medical records clerk, unit secretary, activities director, activities assistant, Social Services coordinator, admissions coordinator, therapy staff, dining	

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{F 226}	Continued From page 37 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	services employees, housekeeping staff, laundry services staff, maintenance staff, personal care services staff and supervisor, receptionist, Resident Services Director, activities and wellness staff for independent living areas, Pharmacy Consultants, Couriers, and Information Technology (IT) Contractors, Attending Physicians, Medical Equipment Sales Representative and Service Personnel, Medical Supplies Sales Representative, Psychological Services – Nurse Practioner and Social Worker, Chemical Sales Representatives, Hospice, Phlebotomist, Newspaper Carrier, Care Coordinator for Medicaid State Insurance Program, Medical Director, Dentist, Dental Hygienist, Registered Dietician. • 1/24/12: New Hire Orientation information was updated to include the policy revisions for "Abuse Prevention" and "Cell Phone Usage." • 1/26/12: The roster of current individuals employed at Appalachian Christian Village was used to ensure each employee was contacted and instructed on the revised policies. Acknowledgement forms have been signed and are maintained in each employee's personnel file by Human Resources personnel of Appalachian Christian Village. A list of persons in-serviced is attached for reference **(See Attachment "C")**	

DEPARTMENT OF HEALTH & HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

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(F 226)	Continued From page 38 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	(F 226)	• 2/8/12 – The facility Administrator began contacting individuals/companies to engage them to provide services as outlined in the Federal Directed Plan of Correction: 1) Independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and any agency staff providing services within the facility, 2) To evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care, 3) Conduct training for the governing body and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect, 4) Provide information to residents during a resident council meeting on abuse, 5) Conduct on a weekday and weekend a meeting with family council or with family members if a council has not been established. The following were contacted: 1) Psychologist, PhD referred by Legal Nurse Consultant who specializes in this type of training, 2) Geriatric Psychiatric Physicians group 3) RN – Certified in Psychiatric Nursing, 4) Quality Improvement Organizations (Q Source) "*Sharing Knowledge, Improving Health Care, Centers for Medicare and Medicaid Services*, 5) A Master in Social Work (MSW), 6) Regional Administrator of a Long Term Care	

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(F 226)	Continued From page 39 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	(F 226)	Corporation, 7) IPC (Inpatient Care Services) and 8) Tennessee Technology Center – RN Educators. On 2/22/12 the facility CEO and Administrator agreed verbally to engage the services of Lipscomb University with (this), Dean of the New College of Professional Studies and The School of TransformAging. On 2/27/12 a contract was signed for those services. Services are planned to begin 2/28/12 and end 3/9/12. **(See Attachment "O" for the contract).** • 2/14/12: All nursing supervisory personnel (DON, ADON, MDS Nurse, RN Supervisor, and LPN Charge Nurse) had completed the "Management/Leadership" in-service. The titles of the courses are: "Critical Thinking – Implications for Long Term Care Leadership"; "Coaching: Implications for Long Term Care Leadership"; and "Ethical Decision Making in Senior Care." **(See Attachment "J")** • 2/15/12: Pre and post test scores were reviewed by the DON and ADON to determine staff competency and if further education is needed. Results: 15 = 100 and 11= 90. • 1/27/12: The Administrator and Director of Nursing reviewed the function of RN supervisors, LPN charge nurses, and the Quality Assurance LPN. • 3/4/12 and 3/5/12: The Social Worker implemented a Family Council based on 6	

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(F 226)	Continued From page 40 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	(F 226)	favorable responses from family members who expressed an interest in the council. **(See Attachment "P" for Family Council information)** • 2/8/12: The DON and ADON developed an additional resident monitoring process to monitor resident care and if care was given in a compassionate, caring manner. The charge nurse conducts clinical rounds for his/her assignment at least 2 times each shift. Results are recorded on the "Clinical Round Worksheet" and forwarded to the DON and or ADON. **(See Attachment "F").** This monitoring process is ongoing. • 1/31/12: A grievance program was developed and implemented by the Director of Nursing. The DON will maintain a log of complaints and will follow up on each complaint regarding patient care issues promptly. This program is in addition to the current policy/procedure in place that is overseen by the Social Services Coordinator. Complaint/grievance reporting forms are located by the bulletin board that houses the public postings and information. These forms are accessible to all employees, residents, family and visitors. **(See Attachment "H")** • 2/8/12: Facility engaged the services of an Independent Nurse Consultant to assist with the POC process and system implementation to address issues identified	

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(F 226)	Continued From page 41 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	(F 226)	in the statement of deficiencies. The Nurse Consultant will continue to evaluate compliance during routine visits. • 2/8/12: Additional rounds were implemented to be conducted by the Management team. Members of the management team (Administrator, DON, ADON, QA Nurse, MDS Nurses, Social Worker/Admission Coordinator and the Activities Coordinator) will round in the facility at least once daily on the night shift between 12mn and 7 am, every day for at least 30 days to monitor resident care and interaction. • 2/11/12: Process was developed to enhance the communication between the DON/ADON and Administrator of daily activities that occur in the Health Care Center during "off" hours and weekends. "Off" hours are defined as hours outside the normal work scheduled times (8:00a.m. – 4:30 p.m.) **(See Attachment "K")** • 2/7/12: Staff is asked by Charge Nurses at the beginning of each staff rotation if they understand the cell phone policy and if they have cell phones with them. If found non- compliant, cell phones are taken immediately, per policy. **(See Attachment "I" for New Rotation Rounds policy)**	

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{F 226}	Continued From page 42 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	**4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i. e. quality assurance measures implemented.** • 2/14/12: The Quality Assurance Nurse will monitor resident care, call light response times, direct care staff to resident interaction, resident conditions, family/visitor concerns during daily rounds Monday – Friday. These rounds will also be conducted at least 1 shift on a weekend each month. This monitoring process is ongoing **(See Attachment L).** • 2/14/12 – Social Services Coordinator and/or the Social Worker/Admissions Coordinator will ~~randomly~~ interview 5 cognitive/interviewable residents (selecting different residents each week) to determine if care is provided in a caring compassionate manner and if they have noticed any behavior from staff that may be consistent with abuse or neglect. These interviews will be completed weekly times 2 weeks, then monthly times 3 months and quarterly thereafter. **(See Attachment M).** • 2/14/12 – Human Resources will conduct interviews with at least 10 employees of all disciplines (selecting different employees each week) to determine if they are knowledgeable of the Abuse Prevention policy and Cell Phone Policy, weekly times 2 weeks, then monthly times 3 months, then quarterly thereafter. **(See Attachment N).**	

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{F 226}	Continued From page 43 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not reour and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• The results of the Quality Assurance Monitoring mentioned above will be reviewed and discussed in the monthly facility Quality Assurance Meeting. The information will be presented as follows: 1) Attachment F: Clinical Rounds by DON 2) Attachment L: Clinical Rounds by QA Nurse 3) Attachment M: Resident Interviews by Social Services Coordinator 4) Attachment N: Human Resources Director 5) Meeting minutes from Family Council Meetings • The Administrator will issue a written report weekly of any activity related to suspected Abuse and or Neglect to the CEO weekly for the next 4 weeks, then monthly for 3 months and quarterly thereafter. The CEO will review the report to determine if appropriate interventions were taken to protect the residents residing Health Care and if facility policy was followed. The CEO or Administrator will present this information to the QA committee for review and discussion in the first monthly meeting following the fourth weekly report, and quarterly thereafter. The CEO will also present this information to the Governing Board at the quarterly Board meetings.	

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{F 226}	Continued From page 44 policies implemented on January 23, 2012, for stopping and reporting abuse, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012. The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}		
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on survey results dated January 31, 2012, the facility failed to be administered in a manner to enforce the facility's abuse policy to protect two Residents (#1 and #2) with Dementia from abuse; to immediately suspend the three alleged perpetrators; failed to ensure policies were followed for investigation and reporting of the abuse; and failed to ensure Residents were protected from further abuse of five Residents reviewed.	{F 490}	**F490** **1) The corrective actions that have been accomplished for the two residents found to have been affected by the deficient practice:** **RESIDENT #1** • 1/14/12: Clothing and bed linens were changed by Certified Nursing Assistants (CNA) #3 and #8 after having been found wet by Registered Nurse (RN) #1 under the supervision of RN #1.	3/9/12

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{F 490}	Continued From page 45 The facility provided an acceptable Credible Allegation of Compliance on February 13, 2012. A revisit conducted on February 15, 2012, revealed the corrective actions, implemented in February 13, 2012, removed the Immediate Jeopardy. Non-compliance for F490 continues at a "D" level scope and severity. Validation of the Credible Allegation of Compliance was accomplished through facility policy review, review of inservice records, interview with staff, administrative personnel, residents and families, and observation. The facility provided evidence of new policies and procedures which was implemented on January 23, 2012, related to the enforcement of stopping and reporting abuse immediately and the enforcement of the cell phone policy, which prohibited the use of personal cell phones and cameras in the facility. The facility provided evidence that all staff, including administrative staff, had been re-inserviced and trained on the facility's abuse policies related to stopping and reporting abuse immediately, protection of the resident, and suspending the alleged perpetrators immediately. Further review confirmed evidence that all staff, including administrative staff, had been in-serviced and trained on the facility's cell phone policies, which prohibits the use of personal cell phones and cameras in the facility. The sign-in sheets for the training records were compared to a listing of all employees and confirmed 100% (percent) of all employees had been trained on the facility's abuse and cell phone policies.	{F 490}	• 1/14/12: After being notified of the allegation, the RN Supervisor did not allow CNA #2, #3, or #4 to enter Resident #1's room and/or perform any care unattended by the RN for the remainder of the shift. At this time, the RN did not know that Resident #2 had been involved in the event that occurred to Resident #1. 1/20/12 was the date the involvement of Resident #2 was discovered. However, all residents assigned to CNAs #2, #3 and # 4 were closely monitored for the remainder of the shift. Resident #2 was in that assignment which was supervised by the RN Supervisor and the Licensed Practical Nurse (LPN) Staff Nurse. Other residents were observed and assessed to ensure appropriate care had been rendered and also observed for signs similar to those reported in the event involving Resident #1 (wet gowns, wet pillow cases, water on the wall or bed). No further signs of unusual or unexpected abuse as observed with Resident #1 were identified by the RN Supervisor or the LPN Charge Nurse during the remainder of the shift. • 1/20/12: MDS assessment was reviewed by Minimum Data Set (MDS) RN. The plan of care was reviewed and revised by the Interdisciplinary Care Plan Team members to reflect the improvement of behaviors. The Interdisciplinary Care Plan Team consisted of: MDS Nurse, Certified Dietary Manager, and the Activities Coordinator. • 1/19/12: Resident #1's husband was notified by the Chief Executive Officer (CEO), Administrator and Director of Nursing (DON) of the allegation. The CEO, Administrator and DON met with the husband on 1/19/12.	

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{F 490}	Continued From page 46 Interview with staff, including Certified Nursing Assistants (CNA's), Restorative Nursing Assistants (RNA's), Licensed Practical Nurses (LPN's), Registered Nurses (RN's), Environmental Services (Housekeeping/Laundry), and Physical Therapist (PT) confirmed staff had been inserviced on the abuse and reporting policies, cell phone policies, and the likelihood of termination for not stopping and reporting abuse, or if caught with a personal cell phone in the facility. Continued interview confirmed at the beginning of each staff rotation, Charge Nurses question staff to ensure understanding of the cell phone policy, and to see if staff have personal cell phones with them. No staff has been caught with their personal cell phone. Interview with the Administrator and the Director of Nursing (DON) confirmed they had been in-serviced and trained by the facility's Chief Executive Officer (CEO) on enforcing abuse and reporting policies and cell phone policies. Random interviews with alert and oriented residents and with family members confirmed no observations had been made of staff with cell phones in the facility. Observation revealed the Crimes Reporting policy was posted in the main lobby, at the time clocks, at the elevators, and in the medicine rooms. Based on review of facility abuse and cell phone policies implemented on January 23, 2012, review of inservice records, interview and observation, the Immediate Jeopardy was removed during the revisit survey dated February 15, 2012.	{F 490}	• 1/20/12: Two daughters were notified by CEO, Administrator, and DON and they met with one of the daughters that same day. • 1/20/12: Attending physician was notified by the Assistant Director of Nursing (ADON) of the reported allegation. • 1/20/12: A sitter was provided by the facility on the night shift (7p-7a). • 1/20/12: Resident #1 was sent to the Emergency Room where a physical exam was performed to ensure no physical/bodily harm had occurred. Findings were negative for any type of physical abuse/harm. • 1/24/12: Resident #1 was evaluated by the Geropsychiatric Nurse Practitioner. Findings: Not significant for mood/behavior changes, documented as "calm and cooperative". • 2/9/12: Administrator requested the Geropsychiatric Nurse Practitioner visit Resident #1 every 2 weeks for at least 2 months. Order obtained by LPN Charge Nurse. RESIDENT #2 • 1/20/12: The Administrator notified the son of the reported allegation. The son did not want to meet, but wanted to discuss the matter on the phone. Administrator offered to have the resident sent to the hospital for a physical exam, but the son declined the offer. • 1/20/12: Skin audit was completed by the Wound Care Nurse on 1/20/12. Findings: Skin intact with no other significant findings.	

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{F 490}	Continued From page 47 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/24/12: The resident was examined by the Geropsychiatric Nurse Practitioner. Results: No changes, continue current medication. • 2/9/12: The Administrator requested the Geropsychiatric Nurse Practitioner visit Resident #2 every 2 weeks for at least 2 months. Order obtained by LPN Charge Nurse. RESIDENT #1 and #2 • 1/17/12: CNAs #2, 3, and 4 were placed on Administrative leave without pay. • 1/17/12: The Administrator and DON viewed CNA #2's cell phone picture gallery. Findings: There were no pictures present of Resident #1, #2, or of any other residents. • 1/19/12: CNAs # 2, 3 and 4 were reported to the local law enforcement by the Administrator. • 1/20/12: After further investigation CNA's #2, 3, and 4 were terminated from employment. • 1/23/12: CNAs #5 and #8 were terminated from employment for failure to report abuse and for providing false information during the investigation.	

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{F 490}	Continued From page 48 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/23/12: The review of policies "Abuse Prevention", "Cellular Phone Usage" and "Crimes Reporting" was conducted by the facility's attorney, the CEO, the Human Resources Director, the Administrator and the Director of Nursing. The revisions of the "Abuse Prevention Policy" and the "Cellular Phone Usage Policy" were carried out by the facility's attorney, with approval of the CEO, the Administrator and the Human Resources (HR) Director. • 1/24/12: Human Resources Director disciplined CNA #7 with a final written warning for failure to report suspected abuse and failure to report violations of the cellular phone usage policy. • 1/24/12: CNA #1, who originally reported the incident, was disciplined by Human Resources for failure to timely report any suspicion of abuse and report usage of cell phone at work as in Appalachian Christian Village polices 1) Abuse Prevention and reporting and 2) Cell Phone Usage. A final written warning was issued and placed in the employee's file. • 1/25/12: Human Resources Director disciplined RN #1 with a final written warning and one day suspension (1/26/12). • 1/25/12: CNA #1 sent an email to the Administrator with his resignation without notice. • 1/25/12: Human Resources Director disciplined CNA #6 with a final written warning for failure to report suspected abuse and failure to report violations of the cellular phone usage policy.	

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{F 490}	Continued From page 49 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/26/12: Human Resources Director disciplined LPN #1 with a one day suspension (1/26/12). ABUSE PREVENTION POLICY REVISIONS The content of the revised "Abuse Prevention Policy" training included (revisions in bold italics): *"employees shall immediately report to their supervisor any alleged incidents or suspicions of abuse, neglect, involuntary seclusion and/or misappropriation of resident's property. Incidents include: staff to resident, resident to resident, resident to staff, staff to staff and visitor to resident.* ***Any employee, who is made aware of abuse or suspected abuse, must immediately report to their supervisor.*** *Any employee who fails to report an act or suspicion of abuse will be subject to discipline which may include termination."* **(See Attachment "A")** The revision to the "Abuse Prevention Policy" is the added statement: ***"Any employee who fails to report an act or suspicion of abuse will be subject to discipline which may include termination."*** The Administrator of Appalachian Christian Village shall serve as the Abuse Coordinator. CELL PHONE USAGE POLICY REVISIONS The revised cell phone usage policy states, with revisions in *bold italics:* "Appalachian Christian Village prohibits the use of personal cellular phones ***and cameras*** in any ACV owned building during working hours. Employees will be required to keep personal cellular phones ***and cameras*** in their vehicles and ***shall not use them while they are clocked in on ACV property.***	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPALACHIAN CHRISTIAN VILLAGE	2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601

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{F 490}	Continued From page 50 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	Employees are asked to ensure that friends and family members are aware of the company's policy. If an employee is caught with their personal cellular phone in an ACV building during working hours the cellular phone will be taken from them by their supervisor and will not be returned to them until the end of their shift. ***In the event of an emergency, employees may use the facility phones to receive or make calls."*** "Due to the fact that management staff members are on call 24 hours a day, most of them have been assigned a cellular phone for business ***use and may use them for legitimate business reasons while at work***. Management staff is encouraged to regularly remind employees of their responsibilities in complying with this policy".**(See Attachment "B")** INSERVICES FOR ABUSE POLICY/REPORTING PROCEDURE AND CELL PHONE USAGE • 1/23/12: The HR Director was trained and in-serviced by the facility's attorney. • 1/24/12: The HR Director trained Management Staff (Administrator, DON, and ADON). • 1/23/12 –2/27/12: These policies and procedures have been reviewed, revised and re-issued with individual re-instruction to each and every employee of the facility and contract employees working within the facility. Facility staff was in-serviced by HR, Administrator, DON and/or the ADON. Employees that were trained/in-serviced included Quality Assurance LPN, MDS RN coordinator, MDS LPN, RN supervisors, LPN charge nurses, LPN wound care nurses,	

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OMB NO.

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	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

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{F 490}	Continued From page 51 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	CNAs, Restorative CNAs, house aides, central supply clerk, medical records clerk, unit secretary, activities director, activities assistant, Social Services coordinator, admissions coordinator, therapy staff, dining services employees, housekeeping staff, laundry services staff, maintenance staff, personal care services staff and supervisor, receptionist, Resident Services Director, activities and wellness staff for independent living areas, Pharmacy Consultants, Couriers, and Information Technology (IT) Contractors, Attending Physicians, Medical Equipment Sales Representative and Service Personnel, Medical Supplies Sales Representative, Psychological Services – Nurse Practioner and Social Worker, Chemical Sales Representatives, Hospice, Phlebotomist, Newspaper Carrier, Care Coordinator for Medicaid State Insurance Program, Medical Director, Dentist, Dental Hygienist, Registered Dietician. • 1/24/12: New Hire Orientation information was updated to include the policy revisions for "Abuse Prevention" and "Cell Phone Usage." • 1/26/12: The roster of current individuals employed at Appalachian Christian Village was used to ensure each employee was contacted and instructed on the revised policies. Acknowledgement forms have been signed and are maintained in each employee's personnel file by Human Resources personnel of Appalachian Christian Village. A list of persons in-serviced is attached for reference **(See Attachment "C")**	

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	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

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{F 490}	Continued From page 52 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• Any employee off duty, on leave of absence or vacation, was contacted and required to come to the management office. HR department, or received by mail the specific information for policy changes, or phone conversations took place with these employees for detailed explanation and assurance of their understanding of policy changes, completed by January 26, 2012. No agency employees were being used at the time. No employees were allowed to return to work until these in-services and policy revisions were conducted and acknowledgement received from them. • 1/23/12 – 1/26/12: Contract employees were issued hard copies of the employee notice of the Crimes Reporting policy, with acknowledgements signed by each contract employee. These signed acknowledgements are maintained by the Human Resources Director in her files at the Management office. **(See Attachment "D" for Crimes reporting requirement notice to employees)** • 2/7/12: Staff is asked by Charge Nurses at the beginning of each staff rotation if they understand the cell phone policy and if they have cell phones with them. If found non-compliant, cell phones are taken immediately, per policy. **(See Attachment "I")**	

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{F 490}	Continued From page 53 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 2/10/12: Human Resources notified all nursing supervisory personnel (DON, ADON, MDS Nurse, RN Supervisor, and LPN Charge Nurse) to complete the "Management/Leadership" in-service. The titles of the courses are: "Critical Thinking – Implications for Long Term Care Leadership"; "Coaching: Implications for Long Term Care Leadership"; and "Ethical Decision Making in Senior Care." Pre and post test scores will be reviewed by the DON and ADON to determine staff competency and if further education is needed. **(See Attachment "J")** • To comply with Federal regulations, the Crimes Reporting Policy was posted 1/1/12 and issued to each of the employees through the Silver Chair Education program by the Human Resources Training Coordinator. The Silver Chair Education program is a program that focuses exclusively on the training and education of employees in Senior Care organizations. **(See Attachment "E")** **2) How other residents were identified as having the potential to be affected by the same deficient practice and corrective actions taken:** • 1/20/12 through 2/9/12: Fifty-five (55) family members were contacted and/or interviewed by the Social Services Coordinator regarding any changes in personality, mood or behavior they may have noticed in that resident within the last 3 months. Findings: Issues/concerns reported were forwarded to the DON for follow-up and corrective action.	

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{F 490}	Continued From page 54 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/24/12 through 2/7/12: Thirty-three (33) alert and oriented residents with a BIM score of 10 or above on the most recent MDS assessment were interviewed by the Quality Assurance (QA) Nurse and Social Worker/Admissions Coordinator regarding any inappropriate behavior or suspected abuse, neglect or harm. Specific questions were used to conduct the interview. The results of the interview were documented on the sheet with the questions for each individual resident. Findings: No complaints, issues were voiced. No suspected abuse/harm was voiced and/or identified. • 2/6/12: Residents with dementia and/or residents who are not interview able were evaluated for any mood or behavior changes that might indicate any mistreatment or incident of abuse by 8 LPN charge nurses. Findings: No changes or issues identified. The results of the evaluations were documented in nurse's notes. No suspected abuse/harm was voiced and/or identified. • 2/8/12: Facility engaged the services of an independent Nurse Consultant to assist with the POC process and system implementation to address issues identified in the statement of deficiencies. The Nurse Consultant will continue to evaluate compliance during routine visits. • 2/8/12: The DON and ADON developed an additional resident monitoring process. **(See Attachment "F")**	

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{F 490}	Continued From page 55 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 2/8/12 – 2/11/12: All residents were given a copy of "Resident Rights" by the Social Services Coordinator. Twenty-three (23) were mailed to the family or power of attorney (POA) (for residents who were considered to have cognitive impairment) and seventy-three (73) were given to residents and signed. • 2/8/12 – The facility Administrator began contacting individuals/companies to engage them to provide services as outlined in the Federal Directed Plan of Correction: 1) Independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and any agency staff providing services within the facility, 2) To evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care, 3) Conduct training for the governing body and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect, 4) Provide information to residents during a resident council meeting on abuse, 5) Conduct on a weekday and weekend a meeting with family council or with family members if a council has not been established. The following were contacted: 1) Psychologist, PhD referred by Legal Nurse Consultant who specializes in this type of training, 2) Geriatric Psychiatric Physicians group 3) RN – Certified in Psychiatric Nursing, 4) Quality Improvement Organizations (Q Source) "*Sharing Knowledge, Improving Health Care, Centers for Medicare and Medicaid Services*, 5) A Master in Social Work (MSW), 6) Regional Administrator of a Long Term Care Corporation, 7) IPC (Inpatient Care Services)	

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{F 490}	Continued From page 56 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	and 8) Tennessee Technology Center – RN Educators. On 2/22/12 the facility CEO and Administrator agreed verbally to engage the services of Lipscomb University with the J, Dean of the New College of Professional Studies and the School of TransformAging. On 2/27/12 a contract was signed for those services. Services are planned to begin 2/28/12 and end 3/9/12. **(See Attachment "O" for the contract).** • 2/11/12: Letters were mailed by the Social Services Coordinator to family members to determine if they are interested in establishing a Family Council. **(See Attachment "G")** **3) Measures or systematic changes put into place to ensure the deficient practice does not reoccur.** • 1/23/12: The "Abuse Prevention Policy" and the "Cellular Phone Usage Policy" were revised by the facility's attorney, with approval of the CEO, the Administrator and the Human Resources (HR) Director. ABUSE PREVENTION POLICY REVISIONS The content of the revised "Abuse Prevention Policy" training included (revisions in bold italics): *"employees shall immediately report to their supervisor any alleged incidents or suspicions of abuse, neglect, involuntary seclusion and/or misappropriation of resident's property. Incidents include: staff to resident, resident to resident, resident to staff, staff to staff and visitor to resident. **Any employee, who is made aware of abuse or suspected abuse, must immediately report to their supervisor.** Any employee who fails to report an act or suspicion of abuse will be*	

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{F 490}	Continued From page 57 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	*subject to discipline which may include termination."* **(See Attachment "A").** The Administrator of Appalachian Christian Village shall serve as the Abuse Coordinator. CELL PHONE USAGE POLICY REVISIONS The revised cell phone usage policy states, with revisions in ***bold italics:*** "Appalachian Christian Village prohibits the use of personal cellular phones ***and cameras*** in any ACV owned building during working hours. Employees will be required to keep personal cellular phones ***and cameras*** in their vehicles and ***shall not use them while they are clocked in on ACV property.*** Employees are asked to ensure that friends and family members are aware of the company's policy. If an employee is caught with their personal cellular phone in an ACV building during working hours the cellular phone will be taken from them by their supervisor and will not be returned to them until the end of their shift. ***In the event of an emergency, employees may use the facility phones to receive or make calls."*** "Due to the fact that management staff members are on call 24 hours a day, most of them have been assigned a cellular phone for business ***use and may use them for legitimate business reasons while at work.*** Management staff is encouraged to regularly remind employees of their responsibilities in complying with this policy". **(See Attachment "B")**	

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{F 490}	Continued From page 58 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/23/12: The HR Director was trained and in-serviced by the facility's attorney. • 1/24/12: The HR Director trained Management Staff (Administrator, DON, and ADON). • 1/23/12 – 2/27/12: These policies and procedures have been reviewed, revised and re-issued with individual re-instruction to each and every employee of the facility and contract employees working within the facility. Facility staff was in-serviced by HR, Administrator, DON and/or the ADON. Employees that were trained/in-serviced included Quality Assurance LPN, MDS RN coordinator, MDS LPN, RN supervisors, LPN charge nurses, LPN wound care nurses, CNAs, Restorative CNAs, house aides, central supply clerk, medical records clerk, unit secretary, activities director, activities assistant, Social Services coordinator, admissions coordinator, therapy staff, dining services employees, housekeeping staff, laundry services staff, maintenance staff, personal care services staff and supervisor, receptionist, Resident Services Director, activities and wellness staff for independent living areas, Pharmacy Consultants, Couriers, and Information Technology (IT) Contractors, Attending Physicians, Medical Equipment Sales Representative and Service Personnel, Medical Supplies Sales Representative, Psychological Services – Nurse Practioner and Social Worker, Chemical Sales Representatives, Hospice, Phlebotomist, Newspaper Carrier, Care Coordinator for Medicaid State Insurance Program, Medical Director, Dentist, Dental Hygienist, Registered Dietician.	

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{F 490}	Continued From page 59 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/24/12: New Hire Orientation information was updated to include the policy revisions for "Abuse Prevention" and "Cell Phone Usage." • 1/26/12: The roster of current individuals employed at Appalachian Christian Village was used to ensure each employee was contacted and instructed on the revised policies. Acknowledgement forms have been signed and are maintained in each employee's personnel file by Human Resources personnel of Appalachian Christian Village. A list of persons in-serviced I s attached for reference **(See Attachment "C")** • 2/8/12 – The facility Administrator began contacting individuals/companies to engage them to provide services as outlined in the Federal Directed Plan of Correction: 1) Independent contractor to provide Compassionate and Person Centered Training to the facility's direct care staff and any agency staff providing services within the facility, 2) To evaluate the skills and competency of direct care staff and their ability to provide compassionate, person centered care, 3) Conduct training for the governing body and all facility personnel on how to create and maintain a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect, 4) Provide information to residents during a resident council meeting on abuse, 5) Conduct on a weekday and weekend a meeting with family council or with family members if a council has not been established. The following	

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{F 490}	Continued From page 60 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	were contacted: 1) Psychologist, PhD referred by Legal Nurse Consultant who specializes in this type of training, 2) , Geriatric Psychiatric Physicians group, 3) RN – Certified in Psychiatric Nursing, 4) Quality Improvement Organizations (Q Source) "*Sharing Knowledge, Improving Health Care, Centers for Medicare and Medicaid Services*, 5) A Master in Social Work (MSW), 6) Regional Administrator of a Long Term Care Corporation, 7) IPC (Inpatient Care Services) and 8) Tennessee Technology Center – RN Educators. On 2/22/12 the facility CEO and Administrator agreed verbally to engage the services of Lipscomb University with the Dean of the New School of Professional Studies and the School of TransformAging. On 2/27/12 a contract was signed for those services. Services are planned to begin 2/28/12 and end 3/9/12. **(See Attachment "O" for the contract)** • 2/14/12: All nursing supervisory personnel (DON, ADON, MDS Nurse, RN Supervisor, and LPN Charge Nurse) had completed the "Management/Leadership" in-service. The titles of the courses are: "Critical Thinking – Implications for Long Term Care Leadership"; "Coaching: Implications for Long Term Care Leadership"; and "Ethical Decision Making in Senior Care." **(See Attachment "J" for in-service content)** •2/15/12: Pre and post test scores were reviewed by the DON and ADON to determine staff competency and if further education is needed. Results: 15 scored 100 and 11 scored 90.	

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	445483	A. BUILDING _____ B. WING _____	R-C 02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPALACHIAN CHRISTIAN VILLAGE	2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 490}	Continued From page 61 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/27/12: The Administrator and Director of Nursing reviewed the function of RN supervisors, LPN charge nurses, and the Quality Assurance LPN. • 3/4/12 and 3/5/12: The Social Worker implemented a Family Council based on 10 favorable responses from family members who expressed an interest in the council. **(See Attachment "P" for Family Council information)** • 2/8/12: The DON and ADON developed an additional resident monitoring process to monitor resident care and if care was given in a compassionate, caring manner. The charge nurse conducts clinical rounds for his/her assignment at least 2 times each shift Results are recorded on the "Clinical Round Worksheet" and forwarded to the DON and or ADON. **(See Attachment "F").** This monitoring process is ongoing. • 1/31/12: A grievance program was developed and implemented by the Director of Nursing. The DON will maintain a log of complaints and will follow up on each complaint regarding patient care issues promptly. This program is in addition to the current policy/procedure in place that is overseen by the Social Services Coordinator. Complaint/grievance reporting forms are located by the bulletin board that houses the public postings and information. These forms are accessible to all employees, residents, family and visitors. **(See Attachment "H").**	

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{F 490}	Continued From page 62 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 2/8/12: Facility engaged the services of an Independent Nurse Consultant to assist with the AOC /POC process and system implementation to address issues identified in the statement of deficiencies. The Nurse Consultant will continue to evaluate compliance during routine visits. • 2/8/12: Additional rounds were implemented to be conducted by the Management team. Members of the management team (Administrator, DON, ADON, QA Nurse, MDS Nurses, Social Worker/Admission Coordinator and Activities Coordinator) will round in the facility at least once daily on the night shift between 12mn and 7a, every day for at least 30 days to monitor resident care and interaction. • 2/11/12: Process was developed to enhance the communication between the DON/ADON and Administrator of daily activities that occur in the Health Care Center during "off" hours and weekends. "Off" hours are defined as hours outside of the normal work scheduled times (8:00 a.m. – 4:30 p.m.) **(See Attachment "K").**	

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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{F 490}	Continued From page 63 The facility will remain out of compliance at a Scope and Severity level "D"-a pattern of deficient practice that constitutes no actual harm with potential for more that minimal harm that is not Immediate Jeopardy. The facility remains out of compliance until it provides an acceptable plan of a correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 490}	• 1/31/12: A policy was developed and implemented to provide direction for supervisory staff on conducting clinical rounds, resident interviews, and observation of staff/resident interaction. 2/7/12: "Teachable Moments" was implemented by the DON. This is a program designed to review policy and staff knowledge of: 1) Abuse prevention; 2) Cellular Phone/Camera Use; 3) Elder Justice Act and Crimes Reporting. This review includes specific questions which are asked by the Charge Nurse to each staff member at the beginning of each new rotation. Results are reported to the DON and ADON at the end of the shift **(See Attachment "I").** • 2/12/12: Nurse Consultant, CEO, and Chairman of Board counseled and provided guidance to the Administrator and DON on how to handle allegations of abuse/neglect etc. to ensure action is taken appropriately and in a timely manner and in accordance to facility policy. Written disciplinary actions were placed in their files.	

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